



KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
KATHLEEN SEBELIUS, GOVERNOR
Roderick L. Bremby, Secretary

CP No _____

AGENCY COMPLAINT INVESTIGATION REPORT FORM

(Please attach additional sheets as needed.)

REPORTING AGENCY

Name: _____ Phone No.: _____
Address: _____ E-mail address: _____
(Street/PO Box) (City/State) (Zip Code)

REPORTING PARTY

Name: _____
(Last) (First) (Middle initial) (Title/position)
Address: _____
(Street/PO Box) (City/State) (Zip Code)
Telephone: () ()
(Work) (Home)

INCIDENT INFORMATION

Date of Incident (on or about):

Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident.)

(Over)

Clients involved in the incident are:							
Name		Cognitive Status (T)					
		Alert/Oriented	Confused/Disoriented				
If injured, please describe:							
Witness(es) to the incident were:							
Please note: Witness statements regarding abuse, neglect or exploitation <u>by an agency staff member</u> need to be notarized.			Notarized Written Statement Attached (T)				
Name	Address	Telephone					
Position/Relationship			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> <tr> <td style="height: 60px;"></td> <td></td> </tr> </table>	Yes	No		
Yes	No						
Corrective Actions Taken by the Agency							
Incident Substantiated by the Agency		9 Yes	9 No				
Agency Investigative Report/Documentation Attached?		9 Yes	9 No				
Attestation Statement: I certify that all the information given is true and correct.							
Name		Title					
Regional Managers: Review of information has been completed. Onsite survey:		9 Yes	9 No				
Name		Date					
Report made to law enforcement? 9 Yes 9 No		Police Case # _____					
Name and address of law enforcement contact: _____							
If the alleged perpetrator is a CNA or CMA, please attach nurse aide registry verification.							

Please mail to:

Mary Kabriel, RN, Regional Manager
 Kansas Dept of Health & Environment
 Bureau of Child Care & Health Facilities
 1000 SW Jackson, Suite 200
 Topeka, KS 66612-1365

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY OR AGENCY

Agency: _____

City: _____

ALLEGED PERPETRATOR INFORMATION:

Name: _____
 Last First MI Other

Address: _____
 Street/Box City State Zip Code

Telephone No: () _____ Social Security No.: _____

Date of Hire: _____

AP Suspended? ☐ Yes ☐ No Date: _____ AP Terminated? ☐ Yes ☐ No Date: _____

CREDENTIALING/LICENSURE INFORMATION

Certificate or License No.: _____
 (Attach copy of certificate/license.)

Type of Certification (check those that apply): ☐ NAT ☐ CNA ☐ CMA ☐ HHA ☐ AD ☐ SSD ☐ QMRP

☐ Other _____

NAT = Nurse Aide Trainee I or II CNA = Certified Nurse Aide CMA = Certified Medication Aide
 HHA = Home Health Aide AD = Activities Director SSD = Social Services Designee
 QMRP = Qualified Mental Retardation Professional

OR

Type of License (check those that apply):

☐ ACHA ☐ RN ☐ LPN ☐ RPT ☐ OT ☐ LMHT ☐ LSW ☐ Other _____

ACHA = Adult Care Home Administrator RN = Registered Nurse LPN = Licensed Practical Nurse
 RPT = Registered Physical Therapist OT = Occupational Therapist
 LMHT = Licensed Mental Health Technician LSW = Licensed Social Worker

THIS SECTION TO BE COMPLETED BY THE REGIONAL MANAGER

Case No.: _____ Code No.: _____ Type: _____

The above-named perpetrator has been found to have:

Regional Manager Signature: _____ Date: _____